Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FRWY, SUITE 2200
HOUSTON TX 77027

Carrier's Austin Representative Box
Box Number 42

Respondent Name

OLD REPUBLIC INSURANCE CO

MFDR Date Received
December 12, 2007

MFDR Tracking Number
M4-08-2390-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient was brought to Memorial Hermann Hospital via ambulance and admitted through the ER due severe injuries sustained in the couse [sic] and scope of employment. The patient suffered ra [sic] broken leg, broken ribs and a broken nose as a result of this accident on the job The patient was hospitalized from December 12, 2006 through December 17, 2006." "Due to the nature of the patient's injuries, he required transport via ambulance and emergency services and supplies during his stay." "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred. Requestor is owed an additional $35,450.25, plus interest."

Amount in Dispute: $35,450.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor seeks additional reimbursement under the Acute Care Inpatient Hospital Fee Guidelines. The Requestor has invoked the Stop-Loss provision of Rule 134.401 and seeks additional reimbursement in the amount of $35,450.25 for a five-day overnight inpatient stay with injuries of what appear to be a broken leg, broken ribs, and a broken nose. The Provider/Requestor billed $50,664.25, and the Respondent paid $15,214.00 for dates of service from December 12, 2006 through December 17, 2006. The Requestor now seeks reimbursement in the amount of $35,450.25." "Respondent audited the charges accordingly and issued payment in the amount of $15,214.00. As shown in the EOBs, the charges were reduced or denied on the basis that the bill was reimbursed according to the Provider's contract with Aetna, that the charges exceeded the fee arrangement with Aetna, that non-covered services were denied because they were not medically necessary, and that other charges exceeded any preauthorization. The bills were denied on the basis that the procedure was included with other codes billed on the same day, that additional hospital days were not preauthorized or pre-certified, that professional fees should be reimbursed on HCFA's, that certain services were not medically necessary, that the claim or service lacked the physician/operative or other supporting documentation. The bills were audited and reduced in accordance with the workers' compensation state fee schedule. The auditing company has provided a cost breakdown of the fees associated with its reduction in charges. The Requestor has failed to provide any basis for any 'unusual and customary' fees it charges for these services. Respondent has paid a fair and reasonable rate for the services provided. Respondent has paid according to the Fee Guidelines. No additional reimbursement is owed."

Response Submitted by: Old Republic Insurance Co., P.O. Box 91569, Austin, TX 78735

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2006 through December 17, 2006	Inpatient Services	$35,450.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, 31 TexReg 3566, requires preauthorization for non-emergency inpatient hospitalizations.
4. 28 Texas Administrative Code §133.305, effective December 31, 2006, 31 TexReg 10314, sets out the dispute sequence.
5. 28 Texas Administrative Code §133.308, effective December 31, 2006, 31 TexReg 10314, sets out the procedures for resolving medical necessity disputes.
6. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 112-001-the bill has been reimbursed according to the providers contract with AETNA.
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - 7-The procedure code is inconsistent with the patient's gender.
   - 857-999-Pocedure included in another code billed on same date of service.
   - 868-001-Additional hospital day(s)/item(s) not pre-certified and/or authorized.
   - 868-010-Professional fee must be billed on HCFA. Please resubmit on appropriate form.
   - 873-Reimbursement not recommended; service(s) item(s) not medically necessary for remedial treatment of the work related injury/illness.
   - 877-999-Report necessary for reimbursement. Please resubmit with appropriate report.
   - 885-999-Review of this code has resulted in an adjusted reimbursement.
   - 975-640-Nurse review in-patient hospital/facility/supply house.
   - 97-Payment is included in the allowance for another service/procedure.
   - D19-Claim/service lacks Physician/Operative or other supporting documentation.
   - W1-Workers compensation state fee schedule adjustment.
   - 900-Based on further review, no additional allowance is warranted.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - Bill notes: We have received a request for reconsideration from AHC dated 2/6/07 wherein you are asking

for total charges as the services were trauma related. Per the EOR payment was issued for the first date of service as it was an emergent admission. You may contact Utilization Management…and request a retrospective review of the additional 4 days. In addition, we disallowed professional fees in the amount of $740.00 as payment is made to the physician separately and $1825.75 for the act of injecting medications and IV fluid in the emergency room as these charges have been unbundled. We find our original analysis correct and no additional payment is warranted at this time.

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with the FOCUS_WC_TX network. The network reduction amount on the submitted explanation of benefits dated January 15, 2007 and December 12, 2006, denotes a $0.00. The respondent did not clarify or otherwise address the "45" claim adjustment code upon receipt of the request for dispute resolution, nor was documentation provided to support that there is a contract between the provider and the FOCUS_WC_TX network. For these reasons, the Division finds that the "45" claim adjustment code is not supported.
2. The respondent denied reimbursement for educational training services based upon EOB denial reason code "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer."

   The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on December 12, 2007. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308.

   The requestor has failed to support that the billed charges of $36.25 for education training are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.
3. The respondent denied reimbursement for dates of service December 13, 2006 through December 17, 2006 based upon "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization;" and "868-001-Additional hospital day(s)/item(s) not pre-certified and/or authorized."

   The requestor disagrees with the respondent and contends that additional payment is due because this admission was for emergency services for a trauma diagnoses.

   28 Texas Administrative Code §134.600(c)(1) effective May 2, 2006, states that "c) The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
   (C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
   (D) when ordered by the Commissioner."

   28 Texas Administrative Code §134.600(q)(1) effective May 2, 2006, requires preauthorization for concurrent review for an extension of "inpatient length of stay." No documentation was found to support that the requestor obtained preauthorization approval for concurrent review for inpatient hospitalization in accordance with 28 Texas Administrative Code §134.600(q)(1); therefore, additional payment is not recommended for dates of service December 13, 2006 through December 17, 2006.
4. The claimant sustained a compensable injury on December 12, 2006 when he was involved in a motor vehicle accident.

   The respondent did not deny the initial day of treatment and paid $15,214.00 for services provided on that day.
5. 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is

listed as 812.21. The Division therefore determines that inpatient services rendered on December 12, 2006 shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

6. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that "Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred." Total charges for December 12, 2006 were $30,138.50. The respondent paid $15,214.00; therefore, the amount in dispute is $14,924.50.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:
   - "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources**.**
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		2/27/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.